New Jersey Department of Health and Senior Services
Office of Certificate of Need and Healthcare Facility Licensure
P.O. Box 358
Trenton, NJ 08625-0358

PROCEDURE FOR SUBMISSION OF A WAIVER REQUEST

- A request for waiver from the requirements of the Department of Health and Senior Services' licensing standards or AIA Guidelines for Design and Construction of Hospital and Health Care Facilities shall be submitted to the Department of Health and Senior Services, Office of Certificate of Need and Healthcare Facility Licensure on the attached form.

- Application for Waiver shall be completed for EACH waiver requested and completed in its entirety.

- Application for Waiver shall be submitted by the owner, chief executive officer, chief operating officer or administrator of the existing or proposed facility.

- Application for Waiver shall be submitted to John A. Calabria, Director, at:

  Mailing Address:
  New Jersey Department of Health and Senior Services
  Office of Certificate of Need and Healthcare Facility Licensure
  P. O. Box 358
  Trenton, NJ 08625-0358

  Overnight Services (DHL, FedEx, UPS):
  New Jersey Department of Health and Senior Services
  Office of Certificate of Need and Healthcare Facility Licensure
  171 Jersey Street, Building 5, 1st Floor
  Trenton, NJ 08611-2425

- To obtain additional information regarding the waiver process, please call:

609-292-6552	Team A: for facilities located in Bergen, Hudson, Mercer, Morris, Passaic, Somerset, Sussex and Warren Counties
609-633-9042	Team B: for facilities located in Burlington, Gloucester, Hunterdon, Middlesex, Monmouth and Ocean Counties
609-292-7228	Team C: for facilities located in Atlantic, Camden, Cape May, Cumberland, Essex, Salem and Union Counties

New Jersey Department of Health and Senior Services
Office of Certificate of Need and Healthcare Facility Licensure
P.O. Box 358
Trenton, NJ 08625-0358

APPLICATION FOR WAIVER

(Requests for more than one waiver may not be combined. An Application for Waiver form must be completed for <u>each</u> waiver requested).

CN Ref. #	DCA Ref. #	Facility ID # (if currently licensed)
Name and Address of Facility:		
Name, Address and Telephone Number of Owner, Chief Executive Officer (CEO), Chief Operating Officer (COO), or Administrator of the Existing or Proposed Facility:		
Name, Address and Telephone Number of Architect:		
The owner, CEO, COO or Administrator of the existing or proposed health care facility hereby applies for a waiver to the following regulation (identify regulation by name, code citation (if applicable) and date (if applicable):		

APPLICATION FOR WAIVER (continued)

A. Provide the following information for each rule or part of rule for which a waiver is being requested. Attach additional sheets as necessary.

1. Restate rule or part of rule for which a waiver is being requested and identify the specific rule citation.

2. Describe the reasons for requesting a waiver, including a statement of the type and degree of hardship that would result upon compliance.

3. Describe an alternative proposal to ensure patient safety.

4. Is documentation attached to support the waiver request?

☐No ☐Yes (Identify):

B. Is the project currently under review by the Department of Community Affairs, Health Care Plan Review?

☐No ☐Yes (Identify DCA Reviewer)

C. Is the request for a waiver based on plan review comments by the Department of Community Affairs.

☐No ☐Yes (Attach Comments)

Name of Owner, CEO, COO or Administrator	Title
Signature of Owner, CEO, COO or Administrator	Date